

FILED FEB 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3486

00125

BIRTH NO. <u>49-305363</u>		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3069</u>		Registrar's No. <u>00125</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS CO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Richmond Heights</u>		c. LENGTH OF STAY (In this place) <u>0</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS CO. JEFF BARTACK</u>		d. STREET ADDRESS (If rural, give location) <u>1003 VAN. NOSTRAND</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Marys. Hosp</u>				d. STREET ADDRESS (If rural, give location) <u>1003 VAN. NOSTRAND</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Jean</u>		b. (Middle) <u>Ann</u>		c. (Last) <u>Becker</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 19 1949</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>1-17-49</u>		9. AGE (In years last birthday) If under 1 year: Months Days Hours Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Wm Becker</u>		13b. MOTHER'S MAIDEN NAME <u>Audry Schneider</u>		14. NAME OF HUSBAND-OR-WIFE <u>Wm Becker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Wm Becker 1003 Van Nostrand</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>atelectasis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>161a</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Nil</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan 17, 1949</u> , to <u>Jan 19, 1949</u> , that I last saw the deceased alive on <u>Jan 18, 1949</u> , and that death occurred at <u>3:24</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. J. Vollmer M.D.</u>				23b. ADDRESS <u>5320. Big Bend, Webster Groves</u>		23c. DATE SIGNED <u>1/19/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>1-19-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>LAKE CHARLES</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MO</u>	
DATE REC'D BY LOCAL REG. <u>1-29-49</u>		REGISTRAR'S SIGNATURE <u>Shirley L. Luning</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Wm Becker</u>		ADDRESS <u>Maplewood MO</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.